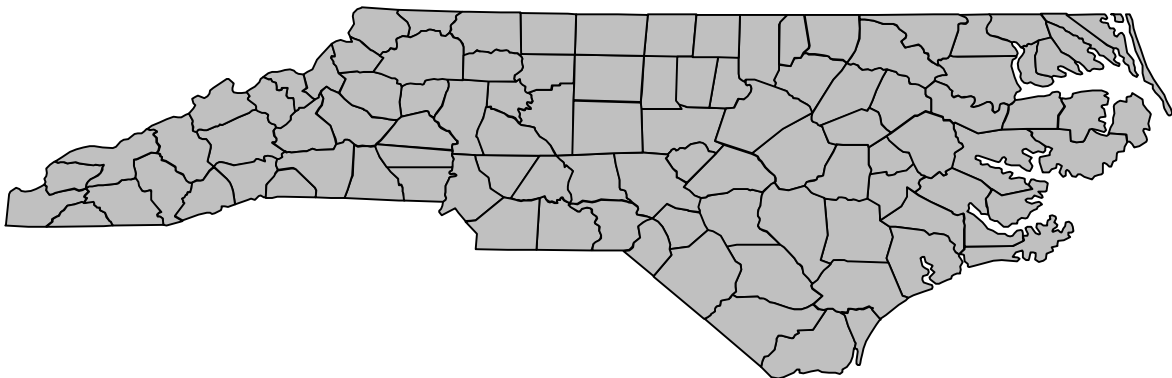


**North Carolina Division of Mental Health, Developmental
Disabilities, and Substance Abuse Services**

**Quarterly Report on
Critical Incidents, Deaths, and
Use of Seclusion and Restraint in Local
Management Entities Catchment Areas**

**State Fiscal Year 2004-2005
First Quarter
July 1, 2004 - September 30, 2004**



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November 2004

Introduction

Purpose

As required by 10A NCAC 27G .0601 through .0609, Local Management Entities (LMEs) are responsible for receiving, reviewing and responding to Incident Reports from Category A and B providers of mental health, developmental disability and substance abuse services in their catchment areas. LMEs are to analyze this collected information as part of their quality management efforts and to report summarized information each quarter to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

This is the fifth statewide quarterly report summarizing this information. The reporting and analysis of information on critical incidents and deaths are an important part of any effort to manage the quality of care being delivered. This statewide report is meant to support local efforts in improving the quality of care being delivered. We hope the information in this report will provide a useful overview of the numbers of critical incidents, deaths, and use of seclusion and restraint being reported across the community system in North Carolina.

Organization

This report is organized into two main sections. The first section of the report summarizes the findings of LMEs with regards to their own analyses of the data, highlighting common areas of concern and some of the quality improvement activities being undertaken.

The second section of the report summarizes aggregate data on critical incidents and deaths, and the use of seclusion and restraint in local areas. The report includes data provided by Category A (NCGS 122C licensed facilities, except hospitals) and Category B (unlicensed community-based) providers. The report does not include data on Category C (hospitals, state-operated facilities, nursing homes, adult care homes, family care homes, foster care homes, or child care facilities) or Category D providers (individuals providing only outpatient or day services that are licensed or certified to practice in the State) that are not covered by these regulations. The types of incidents reported include deaths; allegations of abuse, neglect, or exploitation; injury requiring treatment by a physician; medication errors; the use of seclusion and restraint; and other types of critical incidents.

This statewide reporting of critical incidents is a new process. Accordingly, it is understood that initially there will be some incomplete reporting as the new regulations are fully put into place. Additionally, the process of deciding how best to summarize and share this collected information is likely to change over time as a better understanding of the issues is gained. This is an evolutionary process which should improve over time.

Please give us feedback!

We welcome your suggestions on how we can make this report more useful and more relevant to your questions and concerns. Our address, email, and phone number can be found on the last page of the report. Thank you in advance for your feedback.

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Executive Summary

As was noted in the introduction, the statewide reporting of critical incidents and deaths is an evolving process. The task of implementing this new process is taking place at the same time that other major changes are occurring in the manner local services are being provided and managed. Accordingly, it is understood that initially there will be some incomplete reporting as the new regulations are fully put into place, and it will take time to get all providers fully reporting the required data. This will have an impact on the completeness and quality of the data in the initial statewide reports. It may take some time before the data is considered to be complete enough to provide good baseline information on the rate of occurrence of these incidents.

The **number of providers submitting reports** and the **number of incidents** reported have continued to increase over time indicating better compliance with the reporting requirement. During the first quarter of SFY05, 661 providers submitted a total of 1,934 critical incident and death reports for an average of 2.9 reports per provider.

The rate of reported **critical incidents and deaths** statewide during the first quarter of SFY05 was 7.9 per 1,000 active consumers. This represents a slight increase from the 7.45 average quarterly rate for SFY04. The number of deaths reported during the first quarter of SFY05 increased slightly over the number reported last year. It should be noted that almost three-fifths (58%) of the deaths reported this quarter were due to terminal illness or other natural causes, and one-fourth (25%) were due to unknown causes. Both of these categories accounted for the increased number reported.

The rate of reported **allegations of abuse, neglect, or exploitation** for the first quarter of SFY05 was 1.22 per 1,000 active consumers, which is slightly higher than the 1.19 average rate for the prior two quarters. Three-quarters of these reported allegations involved allegations of abuse.

The number and rate of reported **injuries requiring treatment by a physician** were higher during the first quarter of SFY05 than during previous quarters in SFY04. This quarter, 549 injuries were reported for a rate of 2.24 per 1,000 active consumers. Two-thirds of these injuries were in the "other accident or injury" category. Injuries in this category accounted for the increased numbers reported. Self-injury was the next most common category representing 16% of the total for the quarter.

The number and rate per 1,000 active consumers of **reported medication errors** decreased during the first quarter of SFY05. This quarter a total of 214 medication errors or 0.87 errors per 1,000 active consumers were reported. More than three-quarters (78.5%) of the medication errors were due to missed dose of prescription medications.

The number and rate per 1,000 active consumers of **other reported critical incidents** increased during the first quarter of SFY05. This quarter, a total of 419 other critical incidents or 1.71 other critical incidents per 1,000 active consumers were reported. Client absence without notification accounted for nearly two-thirds (62.5%) of these other critical incidents.

The reported **use of restraint or seclusion at the time of a critical incident** was 0.78 per 1,000 active consumers during the first quarter of SFY05. This was higher than the previous quarter but 22% lower than the SFY04 average quarterly rate of 1.00 per 1,000 active consumers. Almost all of these cases involved physical restraint.

The reporting of **all uses of restraint and seclusion**, including cases where no critical incident happened, and the number of consumers involved were lower in the first quarter of SFY05 than in the previous quarter. Physical restraint represents the majority (94%) of the reported cases. Statewide, the

reported use of physical restraint was 3.38 per 1,000 active consumers this quarter. For consumers who were physically restrained, physical restraint was used an average of 2.07 times per consumer during the quarter. This was down from last year's quarterly average of 2.40 times per consumer.

Because of the relative newness and evolving nature of critical incident reporting, it is difficult to interpret with certainty, at this point in time, the reasons for individual and aggregate increases and decreases in the numbers of incidents and the variability in incident rates from LME to LME. Some of the low rates may reflect underreporting. Some of the higher rates may be due to the inclusion of non-critical incidents that are not required to be reported or incidents that are reported by contract providers due to LME requirements. Some of the increases over time may reflect increases in reporting as providers become educated about their responsibility to report critical incidents. Some of the decreases may be the result of a better understanding of what needs to be reported and may reflect a reduction in unnecessary reporting.

The Division recognizes that more work is needed to ensure statewide consistency in what is reported. To this end, the Division is moving to using a new Critical Incident and Death Reporting Form and instruction manual (effective October 1, 2004) to better identify what is reportable. The Division also plans to continue to work with LMEs to clarify and refine what should be reported to enhance the usefulness and effectiveness of critical incident reporting as a quality management tool.

Assessments by LMEs about the trends in their own catchment areas indicate that many LMEs are devoting a lot of attention to two issues -- provider reporting of incidents and the use of restrictive interventions, particularly the use of physical restraint.

LMEs are closely looking at the numbers of providers that are reporting incidents, the number of incidents being reported, and the quality of the incidents being reported to make sure that providers are appropriately reporting incidents that occur. At least six LMEs reported seeing an increase in the number of providers that are reporting incidents and an improvement in the quality of reporting. Nine LMEs reported concerns about late, under-reporting, or inaccurate reporting of incidents this quarter. A number of LMEs reported steps they are taking to improve reporting, such as communicating with providers, posting the DHHS Incident and Death Report form (QM02) on their websites, providing additional training to providers, and making this an agenda item at quarterly provider meetings. Based on LMEs internal assessments, progress is being made, but more work is needed in this area.

LMEs are closely monitoring and working with local providers to reduce the use of restraints. Several LMEs reported seeing an increase in the number of restraints reported. In a number of cases, the increase was due to an increase in the number of providers reporting. Several LMEs reported their plans to monitor usage for a period of time before making any conclusions about appropriateness. Several LMEs identified patterns of inappropriate use of restraints and expressed concern that some providers may be inappropriately resorting to the use of physical restraint too quickly or too often without first attempting less restrictive alternative interventions. One LME indicated relocating several clients placed in residential treatment when it was noted that the provider had an unacceptable pattern of utilization of physical restraints and/or they received complaints from parents/guardians. Several LMEs reported on their efforts to decrease the use of physical restraint by working with treatment teams, providers' Client Rights Committees, and providing more education to providers.

Although critical incident reporting is in its early stages of implementation and more refinement is needed, it is clear that critical incident reporting is already helping LMEs to identify areas in need of improvement, and LMEs and providers are using this information to make improvements.

Local Program Catchment Area Changes

As reform is being implemented in the North Carolina public mental health, developmental disability, and substance abuse service system, local programs are being consolidated and in some cases realigned along different county combinations. These changes can present difficulties in looking at data over time and keeping track of the changes. This added page will list program consolidations or changes as they affect the reporting of critical incident data.

To provide comparisons over time, the choice has been made here to go back to prior data and consolidate it into new program catchment area numbers as the changes occur. By combining the data where possible into the new catchment areas for prior quarters, comparisons of changes over time become possible. It is important to understand that the consolidations will probably affect local program operation and reporting of data by providers. Thus, the prior quarter(s) data from these new programs' catchment areas may not be completely comparable because local administration change may affect provider reporting to some degree. Comparing changes over time in these newly aligned programs should be made with this understanding in mind.

The table below lists old programs, the new program consolidations, and when these changes were effective for the purpose of this quarterly reporting. As new changes are put into place, this table will be updated.

Old Programs	New Program	Changes Effective
Blue Ridge Rutherford-Polk Trend	Western Highlands	Consolidation took place after the end of the second quarter in SFY04. Rutherford-Polk did not report data for second quarter so the numbers for the new area reflect some missing data for the second quarter of SFY04.
Duplin-Sampson Lenoir Wayne	Eastpointe	Consolidation took place before the start of SFY04 so all data reflect the new program.
Sandhills Randolph	Sandhills	Consolidation took place before the start of SFY04 so all data reflect the new program.
Piedmont Davidson	Piedmont	Consolidation took place after the end of the second quarter SFY04. Davidson did not report data for the second quarter so the numbers for the new area reflect some missing data for the second quarter of SFY04.

Summary of Trends Reported

One of the purposes of reporting critical incidents, deaths, and use of seclusion and restraint quarterly is to identify trends and patterns across the state that provide shared opportunities for improvement. Common trends across Local Management Entities (LMEs) may indicate opportunities for LMEs to learn from each other. They may also point to issues that need to be addressed systematically statewide, either by the Division or by the NC Council of Community Programs.

The table below lists patterns identified by LME during the first quarter of reporting. The most common patterns identified continues to be the fluctuation in reporting of incidents. Providers appear to actively participate in various trainings dealing with restrictive interventions, and trends in restrictive interventions appear to be improving.

	Identified Trends	Number (Percent) of LMEs Citing This Issue (33 total)
Critical Incidents	Increased reporting of incidents	6 (18%)
	Late, under- and inaccurate reporting	9 (27%)
	Staff suspended/fired due to being too physical	2 (6%)
	Suspension/expulsion of consumer from program	3 (9%)
	No information reported from LME	2 (6%)
	Abuse allegation resulting in DSS/DFS/local law enforcement contact	1 (3%)
Deaths	Increased reporting of incidents	2 (6%)
	Decreased reporting of incidents	1 (3%)
	No information reported from LME	5 (15%)
Seclusion and Restraints	Increased use of restrictive interventions	3 (9%)
	Decreased use of restrictive interventions	1 (3%)
	No information reported from LME	5 (15%)
	Increased use of restrictive interventions due to start of new school term	2 (6%)
LMEs Use of Reports and Trends	Making decisions on training needs based on trends	4 (12%)

Examples of Trend Analysis Reported

The LMEs reports cited below provide an overview of how LMEs are identifying and responding to patterns in deaths, critical incidents and/or use of seclusion and restraints. Excerpts from these reports are included because they provide good examples of (1) providers' compliance with the reporting process; (2) identification of patterns/trends; and (3) actions being taken in response to trends.

Permission to identify the LMEs being quoted by name has been received from the LMEs who have been cited in this report.

Reporting Compliance

Improved Reporting:

Cumberland

There were 25 new (have not previously reported information) providers submitting critical incidents during this quarter, including 5 that are technically Category C providers. Although these providers are not required to submit critical incidents to the LME, the providers have stated that they are doing this so that a complete picture of their system of services can be seen.

Crossroads Behavioral Healthcare

Increase in providers and they are getting better at submission of incident reports to the LME caused an overall increase in incidents.

Smoky Mountain Center

The number of incidents reported increased dramatically this quarter. This is due to the fact that the area's largest provider previously was not submitting critical incident reports. The LME followed up with this provider, and required reporting is now taking place. All increases in numbers of incidents are due to the previous underreporting problem, not to any actual increase in incidents.

Western Highlands

There has been an increase in reported event totals as LME personnel communicate to providers the necessity and importance of incident reporting. Western Highlands will be training providers on the new state forms and detail tracking.

Wilson-Greene

It appears that the total number of incident reports that I have received have decreased, and that providers are sending in reports more appropriately. In the past we have received critical incident reports on such minor injuries as a hangnail or scraped knee. Currently, it seems as though the reports I am receiving are incidents that should actually be reported to the area program.

Under Reporting:

Alamance-Caswell MH/DD/SA

The number of reported incidents is way down from fourth quarter of 03-04. At this point a trend has not been established. A mailing will go out to providers who are not reporting to review the requirements. A provider forum is scheduled for November 18th; incident reporting will be on the agenda.

Centerpoint Human Services

Only 15 providers submitted Critical Inc./Death Reports, an unacceptably low number. CPHS plans a provider training on the new Incident & Death Report Form (QM02) in Oct 2004 and will address the requirement for providers to submit to LME. Once trained, all providers will be expected to submit these reports using the new form.

Pitt Mental Health

15 providers submitted at least one critical incident or death report to the LME for the 1st quarter SFY 04-05. These numbers reflect the possibility of under reporting and lack of reporting from several providers. Since the formulation of confidence levels, providers that historically did not submit reports have reported critical incidents during the 1st quarter. Pitt area program has scheduled a training for all providers in Pitt County for October to address the new criteria and reporting regulations.

Rockingham County

The area program will discuss the new reporting forms and requirements at the next quarterly provider meetings. In addition, plans are to review these requirements during each subsequent quarterly meeting. We feel we are generally well informed of the care of our clients. Therefore, we are not sure whether the low number of incident reports is due to the quality care of our providers or a lack of understanding of what should be reported. Hopefully, a quarterly review will serve to remind providers of their responsibility to complete incident and restrictive intervention reports and submit them in a timely manner.

Identified Trends and Actions Taken

Changes in the Reported Use of Seclusion and Restraints:

LME	Trend(s) Reported	Action(s) Taken
Albemarle LME	Providers had unacceptable patterns of utilization of physical restraints and/or complaints from parents or guardians.	The Albemarle Mental Health Center/LME relocated several clients placed in residential treatment facilities over the past quarter
Crossroads	Start of new school year increases restraints and seclusion reports. Addition of day treatment capacity also increases incidents.	No action reported.
New River	We have recently begun to receive incident reports from one local provider who serves as a level 3 residential treatment site. They use planned restraints frequently as a treatment modality.	We have begun to monitor the frequency of these incident reports (as related to the individual clients) for six months and if they seem excessive, then we will communicate our concern and try to work with them to develop a less invasive mode of treatment.
Piedmont	A total of 12 providers reported 43 restraints on 23 clients during this quarter. This is an 8% increase of restraints reported and an 18% decrease in the number of consumers involved in the restraints when compared to last quarter.	No action reported.
Southeastern Center	There continues to be concern over the number of restraints used for one particular client. There is a client rights approved behavior plan in place, but level of care remains a concern.	This will be addressed with the treatment team.
Program A	Increased use of restraints by providers. Providers not using least restrictive interventions first. Providers still having difficulty filling our forms correctly and in a timely manner.	Implementing mandatory training for providers on incident reporting.

Changes in Other Incidents Reported:

LME	Trend(s) Reported	Action(s) Taken
Sandhills Center for MH, DD, & SA	<p>Medication Errors increased from 2 last quarter to 20 this quarter. Upon review, 19 incidents of Medication Errors occurred at one facility and were all on the same consumer.</p> <p>Deaths reported decreased from 12 last quarter to 6 this quarter. No trends were identified. There were no deaths reported as Unknown compared to 4 reported last quarter.</p>	<p>Upon contact with the provider, QM staff learned the consumer was refusing to take medications. Staff involved met with the physician, psychiatrist, qualified professional and other responsible staff to improve the situation. All of the actions taken have been well documented. In addition, technical assistance was provided by QM staff to the provider to assure incidents are reported in accordance with the permanent rules.</p> <p>No action reported.</p>
Southeastern Center	<p>There seemed to be an increase in the reporting of self-injurious behavior this quarter. The incidents were among several providers and clients.</p> <p>There continues to be concern over the number of children in HRI Level III homes that are gone without notification for longer than 3 hours.</p>	<p>This will continue to be monitored and further information obtained if it continues to be a trend.</p> <p>This will be addressed with all providers at an upcoming provider meeting to ensure that proper staff ratios and supervision is in place in these facilities.</p>

Improvement Activities

Technical Assistance to Providers:

Mental Health Services of Catawba County

MHSCC continues to work with service providers on reporting restrictive interventions and ensuring that providers establish Client Rights Committees to review client rights issues.

Provider Training:

Centerpoint Human Services

The new Restrictive Interventions Detail Report (QM03), although not a mandatory form, will be offered to providers during the November training, since info on restrictive interventions must accompany some of the reportable incidents.

Cumberland

The new requirements for documentation and submission of information on restrictive interventions is being covered in the provider training on the critical incident response system.

Pathways

Every death is forwarded to the Client Rights Officer for consultation, review and follow-up. Training sessions for every provider within catchment has been scheduled and the new Critical Incident and Death reporting form has been implemented and posted via internet, Provider Network Meetings and forums regarding aggregate reporting forms and Level of incidents that should be reported.

The Customer Service Representative inputs each incident report into a database that will be utilized for monitoring and analysis of type, frequency and severity.

All incident reports are reviewed immediately by the Client Rights Coordinator and investigated as needed. The Quality Improvement Management Team meets weekly to review all concerns, complaints, and incidents.

All forms have been posted on the Internet for accessibility to all providers and are being submitted to the LME as requested.

Program A

This quarter the Quality Management Unit provided a training opportunity to all contracted providers on the critical incident reporting process. While many providers took advantage of this training opportunity, not all providers were present. Providers not attending the training will still be held accountable and responsible for submitting reports accurately and timely despite their choice not to attend. Plans have been made for a second training opportunity to be offered to providers in the 2nd quarter to review the recent changes to the critical incident reporting procedure, as well as to review the new form.

Provider Monitoring:

Pitt

One death by accident this quarter included a consumer in supervised living who aspirated a food item. Staff attempted CPR/First Aid and EMS transported to hospital. Client Rights committee reviewed death as well as Death Review Committee and determined that staff acted appropriately and were up-to-date on necessary training. One death by unknown causes that we are awaiting results from an autopsy, and three deaths by terminal illnesses or other causes. QI Department will be verifying staff qualifications and training updates during on-site monitoring visits.

Development of Internal LME Review Processes:

Western Highlands Network

The committee is presently developing policies and procedures for follow up investigations of deaths, as well as outlining the process for gathering further documentation and identifying responsible personnel. Report request tracking is being implemented to assist in communicating the status of ongoing investigations.

Table 1 - Numbers of Providers Submitting Critical Incident Reports and Numbers of Licensed Providers in Catchment Area

Comparing the numbers of providers who submitted critical incident reports against the numbers of licensed providers in a catchment area provides some insight into the degree of reporting by providers and how widespread critical incidents are. Low numbers of providers reporting relative to the number of licensed providers in a catchment area may point to inadequate reporting of critical incidents. More study over time will be needed to assess this.

The number of providers reporting critical incidents relative to the number of licensed providers ranged from a low of 3.2 percent to a high of 43.8 percent with a statewide average of 16.3 percent.

	Total Number of Providers Who Submitted Critical Incident and Death Reports	Providers Submitting Reports as a Percentage of Total Licensed Providers in Catchment Area	Licensed Providers in Catchment Area			
			Total Licensed Providers in Catchment Area	Residential Group Home Providers	Non-Residential Providers	ICF-MR Providers
Alamance-Caswell	6	7.1%	85	69	11	5
Albemarle	10	19.6%	51	28	19	4
Catawba	17	33.3%	51	31	15	5
Centerpoint	15	12.9%	116	80	25	11
Crossroads	37	41.1%	90	46	34	10
Cumberland	59	24.3%	243	202	30	11
Durham	23	15.5%	148	114	21	13
Eastpointe	22	11.5%	191	146	27	18
Edgecombe-Nash	17	33.3%	51	42	5	4
Foothills	26	23.2%	112	67	34	11
Guilford	26	10.6%	245	198	31	16
Johnston	5	8.9%	56	43	8	5
Lee-Harnett	2	3.2%	63	44	11	8
Mecklenburg	16	4.4%	367	303	35	29
Neuse	7	9.2%	76	45	22	9
New River	15	17.9%	84	39	33	12
Onslow	28	43.8%	64	49	12	3
OPC	14	16.3%	86	56	20	10
Pathways	51	20.0%	255	199	38	18
Piedmont	60	19.9%	301	220	60	21
Pitt	15	21.4%	70	50	12	8
Riverstone	10	41.7%	24	13	6	5
Roanoke-Chowan	11	27.5%	40	27	12	1
Rockingham	4	8.7%	46	36	8	2
Sandhills	32	19.0%	168	118	36	14
Smoky Mountain	7	10.0%	70	45	20	5
Southeastern Center	21	24.1%	87	50	28	9
Southeastern Regional	20	14.1%	142	93	38	11
Tideland	4	6.9%	58	33	17	8
VGFW	17	23.3%	73	56	13	4
Wake	24	9.1%	264	209	36	19
Western Highlands	32	16.2%	197	127	52	18
Wilson-Greene	8	11.1%	72	58	11	3
All LMEs Reporting	661	16.3%	4,046	2,936	780	330
Minimum		3.2%				
Median		16.3%				
Maximum		43.8%				

Table 2 - Average Number of Reports per Provider

The average number of critical incident and death reports per provider provides some insight into the level of reporting and of how concentrated the incidents are by provider.

The number of providers that submitted reports has continued to grow each quarter. The average number of reports per provider ranged between 1 and 11 this quarter, with the statewide average being 2.9.

	Total Number of Providers Who Submitted Critical Incident and Death Reports				Average Number of Reports per Provider Filing Reports			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	6				1.5			
Albemarle	10				2.8			
Catawba	17				4.1			
Centerpoint	15				1.9			
Crossroads	37				2.3			
Cumberland	59				1.8			
Durham	23				2.3			
Eastpointe	22				3.9			
Edgecombe-Nash	17				2.8			
Foothills	26				2.8			
Guilford	26				3.5			
Johnston	5				2.2			
Lee-Harnett	2				1.0			
Mecklenburg	16				11.0			
Neuse	7				5.3			
New River	15				2.9			
Onslow	28				4.1			
OPC	14				1.4			
Pathways	51				2.8			
Piedmont	60				3.5			
Pitt	15				1.6			
Riverstone	10				2.0			
Roanoke-Chowan	11				1.5			
Rockingham	4				1.5			
Sandhills	32				2.5			
Smoky Mountain	7				2.1			
Southeastern Center	21				2.6			
Southeastern Regional	20				2.7			
Tideland	4				3.3			
VGFW	17				1.6			
Wake	24				3.8			
Western Highlands	32				2.6			
Wilson-Greene	8				2.4			
All LMEs Reporting	661	0	0	0	2.9	0.0	0.0	0.0
Minimum					1.0			
Median					2.6			
Maximum					11.0			

Table 3 - Numbers and Rates of Total Critical Incident and Death Reports Received

This table shows the total number of Critical Incident and Death reports filed by local providers in each catchment area and the relative rate per 1,000 consumers on the active caseload. Because programs vary substantially in size, comparisons across program are more appropriately done after adjusting for these differences. Although active caseload probably represents the best measure of size, it is important to note that a few areas have substantial numbers of consumers from other areas not on their active caseload but being served in their local residential programs which may have the effect of increasing their relative rates. Further study of this will be done over time to see if additional adjustments need to be made for the rates.

Statewide, the average rate of Critical Incidents and Deaths reported was 7.9 per 1,000 active caseload for this quarter. This represents a slight increase from last year's average rate of 7.45 per 1,000 active caseload and may reflect a higher number of reported critical incidents and deaths. There is still wide variation from program to program and between quarters for individual programs.

	Total Number of Critical Incident and Death Reports				Rate of Total Critical Incident and Death Reports per 1,000 Active Caseload			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	9				1.5			
Albemarle	28				9.0			
Catawba	69				23.7			
Centerpoint	28				2.3			
Crossroads	86				17.4			
Cumberland	104				21.4			
Durham	53				9.5			
Eastpointe	86				8.6			
Edgecombe-Nash	47				13.8			
Foothills	72				13.0			
Guilford	92				6.2			
Johnston	11				3.2			
Lee-Harnett	2				0.5			
Mecklenburg	176				4.3			
Neuse	37				7.1			
New River	43				8.8			
Onslow	115				22.0			
OPC	20				3.2			
Pathways	143				15.0			
Piedmont	210				25.3			
Pitt	24				6.0			
Riverstone	20				5.2			
Roanoke-Chowan	16				3.8			
Rockingham	6				2.6			
Sandhills	80				8.8			
Smoky Mountain	15				2.0			
Southeastern Center	55				8.5			
Southeastern Regional	53				5.5			
Tideland	13				2.3			
VGFW	27				6.0			
Wake	91				8.9			
Western Highlands	84				8.6			
Wilson-Greene	19				3.1			
All LMEs Reporting	1,934	0	0	0	7.9	0.0	0.0	0.0
Minimum					0.5			
Median					7.1			
Maximum					25.3			

Table 4 - Numbers of Reported Deaths by Cause of Death

This table summarizes the numbers of deaths reported by cause of death. Almost three-fifths (58%) of deaths reported were due to terminal illness or natural causes. One-quarter (25%) of deaths were due to unknown causes.

	Number of Deaths Reported																							
	All Deaths				Suicide				Accident				Homicide/Violence				Terminal Illness or Other Natural Cause				Unknown Cause			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	3				0				0				0				2				1			
Albemarle	1				1				0				0				0				0			
Catawba	2				0				0				0				1				1			
Centerpoint	1				0				0				0				1				0			
Crossroads	12				0				0				0				2				10			
Cumberland	8				0				1				2				4				1			
Durham	3				0				0				1				1				1			
Eastpointe	0				0				0				0				0				0			
Edgecombe-Nash	2				0				1				0				1				0			
Foothills	5				0				1				0				3				1			
Guilford	15				1				0				0				12				2			
Johnston	1				0				0				0				0				1			
Lee-Harnett	0				0				0				0				0				0			
Mecklenburg	4				0				0				0				3				1			
Neuse	2				0				0				0				0				2			
New River	6				2				1				0				1				2			
Onslow	0				0				0				0				0				0			
OPC	2				0				0				0				1				1			
Pathways	9				1				0				0				4				4			
Piedmont	20				1				1				0				14				4			
Pitt	5				0				1				0				3				1			
Riverstone	6				1				0				0				5				0			
Roanoke-Chowan	0				0				0				0				0				0			
Rockingham	2				0				0				1				0				1			
Sandhills	6				2				0				0				4				0			
Smoky Mountain	0				0				0				0				0				0			
Southeastern Center	8				0				0				0				8				0			
Southeastern Regional	11				0				0				0				11				0			
Tideland	0				0				0				0				0				0			
VGFW	0				0				0				0				0				0			
Wake	7				1				0				0				5				1			
Western Highlands	8				3				2				1				0				2			
Wilson-Greene	0				0				0				0				0				0			
All LMEs Reporting	149	0	0	0	13	0	0	0	8	0	0	0	5	0	0	0	86	0	0	0	37	0	0	0

Table 5 - Rate of Reported Deaths per 1,000 Active Consumers by Cause of Death

This table summarizes the rate of reported deaths per 1,000 active clients. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

Statewide, the average number of deaths per 1,000 active clients was 0.61 this quarter. This shows a slight increase from prior quarters, and appears to be due to an increase in the number of reported deaths from terminal illness, other natural causes, and unknown causes.

	Rate of Deaths per 1,000 Active Consumers																							
	All Deaths				Suicide				Accident				Homicide/Violence				Terminal Illness or Other Natural Cause				Unknown Cause			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.51				0.00				0.00				0.00				0.34				0.17			
Albemarle	0.32				0.32				0.00				0.00				0.00				0.00			
Catawba	0.69				0.00				0.00				0.00				0.34				0.34			
Centerpoint	0.08				0.00				0.00				0.00				0.08				0.00			
Crossroads	2.43				0.00				0.00				0.00				0.41				2.03			
Cumberland	1.64				0.00				0.21				0.41				0.82				0.21			
Durham	0.54				0.00				0.00				0.18				0.18				0.18			
Eastpointe	0.00				0.00				0.00				0.00				0.00				0.00			
Edgecombe-Nash	0.59				0.00				0.29				0.00				0.29				0.00			
Foothills	0.91				0.00				0.18				0.00				0.54				0.18			
Guilford	1.01				0.07				0.00				0.00				0.81				0.13			
Johnston	0.29				0.00				0.00				0.00				0.00				0.29			
Lee-Harnett	0.00				0.00				0.00				0.00				0.00				0.00			
Mecklenburg	0.10				0.00				0.00				0.00				0.07				0.02			
Neuse	0.38				0.00				0.00				0.00				0.00				0.38			
New River	1.22				0.41				0.20				0.00				0.20				0.41			
Onslow	0.00				0.00				0.00				0.00				0.00				0.00			
OPC	0.32				0.00				0.00				0.00				0.16				0.16			
Pathways	0.94				0.10				0.00				0.00				0.42				0.42			
Piedmont	2.41				0.12				0.12				0.00				1.69				0.48			
Pitt	1.25				0.00				0.25				0.00				0.75				0.25			
Riverstone	1.57				0.26				0.00				0.00				1.31				0.00			
Roanoke-Chowan	0.00				0.00				0.00				0.00				0.00				0.00			
Rockingham	0.85				0.00				0.00				0.43				0.00				0.43			
Sandhills	0.66				0.22				0.00				0.00				0.44				0.00			
Smoky Mountain	0.00				0.00				0.00				0.00				0.00				0.00			
Southeastern Center	1.24				0.00				0.00				0.00				1.24				0.00			
Southeastern Regional	1.14				0.00				0.00				0.00				1.14				0.00			
Tideland	0.00				0.00				0.00				0.00				0.00				0.00			
VGFW	0.00				0.00				0.00				0.00				0.00				0.00			
Wake	0.69				0.10				0.00				0.00				0.49				0.10			
Western Highlands	0.82				0.31				0.21				0.10				0.00				0.21			
Wilson-Greene	0.00				0.00				0.00				0.00				0.00				0.00			
All LMEs Reporting	0.61	0.00	0.00	0.00	0.05	0.00	0.00	0.00	0.03	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.35	0.00	0.00	0.00	0.15	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00				0.00				0.00			
Median	0.59				0.00				0.00				0.00				0.18				0.10			
Maximum	2.43				0.41				0.29				0.43				1.69				2.03			

Table 6 - Numbers of Reported Allegations of Abuse, Neglect or Exploitation of Consumers

This table summarizes the numbers of reported allegations of abuse, neglect, or exploitation of consumers. Abuse represents three-quarters of the reported allegations.

	Reported Allegations of Abuse, Neglect, or Exploitation															
	Total Reported Allegations (Unduplicated)				Alleged Abuse				Alleged Neglect				Alleged Exploitation			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	1				1				0				0			
Albemarle	1				0				1				0			
Catawba	2				2				0				0			
Centerpoint	4				3				1				0			
Crossroads	14				10				4				0			
Cumberland	27				18				6				3			
Durham	4				3				1				0			
Eastpointe	19				19				0				0			
Edgecombe-Nash	5				5				0				0			
Foothills	7				5				2				0			
Guilford	3				2				1				0			
Johnston	3				0				3				0			
Lee-Harnett	1				1				0				0			
Mecklenburg	20				17				3				0			
Neuse	8				5				4				1			
New River	7				3				3				1			
Onslow	8				5				3				0			
OPC	2				2				0				0			
Pathways	22				18				4				0			
Piedmont	48				39				8				1			
Pitt	2				2				0				0			
Riverstone	4				2				2				0			
Roanoke-Chowan	6				4				2				0			
Rockingham	1				1				0				0			
Sandhills	31				21				9				1			
Smoky Mountain	6				4				1				1			
Southeastern Center	4				3				0				0			
Southeastern Regional	7				5				2				0			
Tideland	6				3				3				0			
VGFW	6				3				2				1			
Wake	5				4				1				0			
Western Highlands	10				7				1				2			
Wilson-Greene	4				4				0				0			
All LMEs Reporting	298	0	0	0	221	0	0	0	67	0	0	0	11	0	0	0

Table 7 - Rates of Reported Allegations of Abuse, Neglect, or Exploitation per 1,000 Active Consumers

This table summarizes the rates of reported allegations of abuse, neglect, or exploitation per 1,000 active consumers. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

The average rate of reported allegations of abuse, neglect, or exploitation statewide was 1.22 per 1,000 active caseload in this quarter which is slightly higher than the 1.19 average rate for the prior two quarters. The variation in rates by area program may be more reflective of differences in reporting.

Rate of Reported Allegations of Abuse, Neglect, or Exploitation per 1,000 Active Consumers																
	Total Reported Allegations (unduplicated)				Alleged Abuse				Alleged Neglect				Alleged Exploitation			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.17				0.17				0.00				0.00			
Albemarle	0.32				0.00				0.32				0.00			
Catawba	0.69				0.69				0.00				0.00			
Centerpoint	0.33				0.24				0.08				0.00			
Crossroads	2.84				2.03				0.81				0.00			
Cumberland	5.54				3.70				1.23				0.62			
Durham	0.72				0.54				0.18				0.00			
Eastpointe	1.90				1.90				0.00				0.00			
Edgecombe-Nash	1.46				1.46				0.00				0.00			
Foothills	1.27				0.91				0.36				0.00			
Guilford	0.20				0.13				0.07				0.00			
Johnston	0.88				0.00				0.88				0.00			
Lee-Harnett	0.24				0.24				0.00				0.00			
Mecklenburg	0.49				0.41				0.07				0.00			
Neuse	1.53				0.96				0.76				0.19			
New River	1.43				0.61				0.61				0.20			
Onslow	1.53				0.96				0.57				0.00			
OPC	0.32				0.32				0.00				0.00			
Pathways	2.31				1.89				0.42				0.00			
Piedmont	5.79				4.70				0.96				0.12			
Pitt	0.50				0.50				0.00				0.00			
Riverstone	1.04				0.52				0.52				0.00			
Roanoke-Chowan	1.44				0.96				0.48				0.00			
Rockingham	0.43				0.43				0.00				0.00			
Sandhills	3.39				2.30				0.99				0.11			
Smoky Mountain	0.78				0.52				0.13				0.13			
Southeastern Center	0.62				0.47				0.00				0.00			
Southeastern Regional	0.73				0.52				0.21				0.00			
Tideland	1.07				0.53				0.53				0.00			
VGFW	1.33				0.67				0.44				0.22			
Wake	0.49				0.39				0.10				0.00			
Western Highlands	1.03				0.72				0.10				0.21			
Wilson-Greene	0.65				0.65				0.00				0.00			
All LMEs Reporting	1.22	0.00	0.00	0.00	0.90	0.00	0.00	0.00	0.27	0.00	0.00	0.00	0.04	0.00	0.00	0.00
Minimum	0.17				0.00				0.00				0.00			
Median	0.88				0.54				0.18				0.00			
Maximum	5.79				4.70				1.23				0.62			

Table 8 - Numbers of Reported Injuries Requiring Treatment by a Physician

This table summarizes the numbers of reported injuries to consumers requiring treatment by a physician.

The total number of injuries reported the first quarter is higher than the number reported during previous quarters last fiscal year. The increase appears to be primarily due to a higher number of reported injuries in the "other accident or injuries" category. The percentage of reported injuries in each category this quarter remains about the same as it was last year. Two-thirds of the reported injuries fell into the "other accident or injury" category. Self-injury was the next most common category representing 16.2% of the total for the quarter, followed by injury caused by another client (8.4%), followed by injury due to suicide attempt (7.7%).

	Number of Reported Injuries Requiring Treatment by a Physician																							
	Total Reported Injuries				Injury Due to Suicide Attempt				Injury from Use of a Hazardous Substance				Self-Injury				Injury Caused by Another Client				Other Accident or Injury			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0				0				0				0				0				0			
Albemarle	1				1				0				0				0				0			
Catawba	10				0				0				1				3				6			
Centerpoint	15				2				0				0				1				12			
Crossroads	30				3				0				2				1				24			
Cumberland	23				2				0				4				1				16			
Durham	23				1				0				5				1				16			
Eastpointe	40				1				0				9				5				25			
Edgecombe-Nash	12				2				0				4				1				5			
Foothills	25				1				0				0				1				23			
Guilford	25				0				0				3				0				22			
Johnston	1				0				0				0				0				1			
Lee-Harnett	1				0				0				0				0				1			
Mecklenburg	54				4				0				5				6				39			
Neuse	14				0				0				1				3				10			
New River	9				1				0				2				1				5			
Onslow	20				2				0				2				4				12			
OPC	6				0				0				1				0				5			
Pathways	42				5				0				9				5				23			
Piedmont	61				6				2				8				3				42			
Pitt	8				1				0				1				1				5			
Riverstone	7				0				0				2				0				5			
Roanoke-Chowan	8				1				0				0				0				7			
Rockingham	1				1				0				0				0				0			
Sandhills	21				2				0				1				3				15			
Smoky Mountain	4				0				0				1				0				3			
Southeastern Center	12				0				0				7				1				4			
Southeastern Regional	6				1				0				5				0				0			
Tideland	6				0				0				1				0				5			
VGFW	5				0				0				1				0				4			
Wake	27				5				0				4				1				17			
Western Highlands	24				0				0				6				4				14			
Wilson-Greene	8				0				0				4				0				4			
All LMEs Reporting	549	0	0	0	42	0	0	0	2	0	0	0	89	0	0	0	46	0	0	0	370	0	0	0

Table 9 - Rate of Reported Injuries Requiring Treatment by a Physician per 1,000 Active Consumers

This table summarizes the rate of reported injuries to consumers per 1,000 active consumers. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

The average rate of injuries per 1,000 active consumers statewide for all injuries reported was 2.24 in the first quarter. This represents an increase in the statewide rate from the previous three quarters of last fiscal year and is the same rate as last year's first quarter rate. The increase appears to be primarily due to an increase in the number of reported injuries in the "other accident or injury" category.

Rate of Reported Injuries to Consumers Requiring Treatment by a Physician per 1,000 Active Consumers																								
	Total Reported Injuries				Injury Due to Suicide Attempt				Injury from Use of a Hazardous Substance				Self-Injury				Injury Caused by Another Client				Other Accident or Injury			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.00				0.00				0.00				0.00				0.00				0.00			
Albemarle	0.32				0.32				0.00				0.00				0.00				0.00			
Catawba	3.44				0.00				0.00				0.34				1.03				2.06			
Centerpoint	1.22				0.16				0.00				0.00				0.08				0.98			
Crossroads	6.09				0.61				0.00				0.41				0.20				4.87			
Cumberland	4.72				0.41				0.00				0.82				0.21				3.28			
Durham	4.11				0.18				0.00				0.89				0.18				2.86			
Eastpointe	3.99				0.10				0.00				0.90				0.50				2.49			
Edgecombe-Nash	3.51				0.59				0.00				1.17				0.29				1.46			
Foothills	4.53				0.18				0.00				0.00				0.18				4.17			
Guilford	1.69				0.00				0.00				0.20				0.00				1.48			
Johnston	0.29				0.00				0.00				0.00				0.00				0.29			
Lee-Harnett	0.24				0.00				0.00				0.00				0.00				0.24			
Mecklenburg	1.32				0.10				0.00				0.12				0.15				0.95			
Neuse	2.68				0.00				0.00				0.19				0.57				1.91			
New River	1.84				0.20				0.00				0.41				0.20				1.02			
Onslow	3.83				0.38				0.00				0.38				0.77				2.30			
OPC	0.97				0.00				0.00				0.16				0.00				0.81			
Pathways	4.41				0.52				0.00				0.94				0.52				2.41			
Piedmont	7.36				0.72				0.24				0.96				0.36				5.07			
Pitt	2.01				0.25				0.00				0.25				0.25				1.25			
Riverstone	1.83				0.00				0.00				0.52				0.00				1.31			
Roanoke-Chowan	1.92				0.24				0.00				0.00				0.00				1.68			
Rockingham	0.43				0.43				0.00				0.00				0.00				0.00			
Sandhills	2.30				0.22				0.00				0.11				0.33				1.64			
Smoky Mountain	0.52				0.00				0.00				0.13				0.00				0.39			
Southeastern Center	1.86				0.00				0.00				1.09				0.16				0.62			
Southeastern Regional	0.62				0.10				0.00				0.52				0.00				0.00			
Tideland	1.07				0.00				0.00				0.18				0.00				0.89			
VGFW	1.11				0.00				0.00				0.22				0.00				0.89			
Wake	2.64				0.49				0.00				0.39				0.10				1.66			
Western Highlands	2.47				0.00				0.00				0.62				0.41				1.44			
Wilson-Greene	1.31				0.00				0.00				0.65				0.00				0.65			
All LMEs Reporting	2.24	0.00	0.00	0.00	0.17	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.36	0.00	0.00	0.00	0.19	0.00	0.00	0.00	1.51	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00				0.00				0.00			
Median	1.86				0.10				0.00				0.25				0.15				1.31			
Maximum	7.36				0.72				0.24				1.17				1.03				5.07			

Table 10 - Numbers of Reported Medication Errors

This table summarizes the numbers of reported medication errors. More than three-fourths of the medication errors reported this quarter were due to a missed dose. The total number of errors being reported has decreased from previous quarters during last fiscal year.

	Reported Medication Errors															
	Total Medication Errors Reported				Missed Dose of Prescription Medication				Wrong Dosage Administered				Wrong Medication Administered			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	1				1				0				0			
Albemarle	0				0				0				0			
Catawba	22				18				4				0			
Centerpoint	4				4				0				0			
Crossroads	20				15				2				3			
Cumberland	19				14				2				3			
Durham	4				4				0				0			
Eastpointe	7				6				0				1			
Edgecombe-Nash	3				3				0				0			
Foothills	34				30				1				3			
Guilford	1				0				0				1			
Johnston	0				0				0				0			
Lee-Harnett	0				0				0				0			
Mecklenburg	12				4				4				4			
Neuse	13				12				1				0			
New River	5				1				1				3			
Onslow	7				7				0				0			
OPC	0				0				0				0			
Pathways	5				4				1				0			
Piedmont	7				2				5				0			
Pitt	0				0				0				0			
Riverstone	0				0				0				0			
Roanoke-Chowan	0				0				0				0			
Rockingham	1				1				0				0			
Sandhills	20				20				0				0			
Smoky Mountain	0				0				0				0			
Southeastern Center	2				1				0				1			
Southeastern Regional	0				0				0				0			
Tideland	0				0				0				0			
VGFW	8				7				0				1			
Wake	17				12				5				0			
Western Highlands	1				1				0				0			
Wilson-Greene	1				1				0				0			
All LMEs Reporting	214	0	0	0	168	0	0	0	26	0	0	0	20	0	0	0

Table 11 - Rate of Reported Medication Errors per 1,000 Active Consumers

This table summarizes the rate of reported medication errors per 1,000 active consumers. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

Based on the reported data, there was 0.87 medication errors per 1,000 active consumers in the first quarter. This is slightly lower than previous quarters' trends. The wide variation in rates among area programs is likely due to variation in reporting.

	Rate of Reported Medication Errors per 1,000 Active Consumers															
	Total Medication Errors Reported				Missed Dose of Prescription Medication				Wrong Dosage Administered				Wrong Medication Administered			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.17				0.17				0.00				0.00			
Albemarle	0.00				0.00				0.00				0.00			
Catawba	7.57				6.19				1.38				0.00			
Centerpoint	0.33				0.33				0.00				0.00			
Crossroads	4.06				3.04				0.41				0.61			
Cumberland	3.90				2.87				0.41				0.62			
Durham	0.72				0.72				0.00				0.00			
Eastpointe	0.70				0.60				0.00				0.10			
Edgecombe-Nash	0.88				0.88				0.00				0.00			
Foothills	6.16				5.44				0.18				0.54			
Guilford	0.07				0.00				0.00				0.07			
Johnston	0.00				0.00				0.00				0.00			
Lee-Harnett	0.00				0.00				0.00				0.00			
Mecklenburg	0.29				0.10				0.10				0.10			
Neuse	2.49				2.29				0.19				0.00			
New River	1.02				0.20				0.20				0.61			
Onslow	1.34				1.34				0.00				0.00			
OPC	0.00				0.00				0.00				0.00			
Pathways	0.52				0.42				0.10				0.00			
Piedmont	0.84				0.24				0.60				0.00			
Pitt	0.00				0.00				0.00				0.00			
Riverstone	0.00				0.00				0.00				0.00			
Roanoke-Chowan	0.00				0.00				0.00				0.00			
Rockingham	0.43				0.43				0.00				0.00			
Sandhills	2.19				2.19				0.00				0.00			
Smoky Mountain	0.00				0.00				0.00				0.00			
Southeastern Center	0.31				0.16				0.00				0.16			
Southeastern Regional	0.00				0.00				0.00				0.00			
Tideland	0.00				0.00				0.00				0.00			
VGFW	1.77				1.55				0.00				0.22			
Wake	1.66				1.18				0.49				0.00			
Western Highlands	0.10				0.10				0.00				0.00			
Wilson-Greene	0.16				0.16				0.00				0.00			
All LMEs Reporting	0.87	0.00	0.00	0.00	0.69	0.00	0.00	0.00	0.11	0.00	0.00	0.00	0.08	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00			
Median	0.33				0.20				0.00				0.00			
Maximum	7.57				6.19				1.38				0.62			

Table 12 - Numbers of Other Reported Critical Incidents

This table summarizes the numbers of other types of reported critical incidents. The total number of reported "Other Critical Incidents" increased this quarter from the three prior quarters in SFY04. This quarter a total of 419 other critical incidents were reported. Client absence without notification accounted for nearly two-thirds (62.5%) of these other critical incidents.

	Other Reported Critical Incidents																			
	Client Absence Without Notification for more than 3 Hours				Suspension of a Client from Services				Expulsion of a Client from Services				Arrest of a Client for Violations of Local, State, or Federal Law				Fire or Equipment Failure that has Resulted in Death or Injury			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	3				0				1				0				0			
Albemarle	8				0				0				0				0			
Catawba	4				0				0				1				0			
Centerpoint	5				1				0				1				0			
Crossroads	3				0				0				6				0			
Cumberland	22				0				0				4				0			
Durham	10				1				0				4				0			
Eastpointe	14				0				0				1				0			
Edgecombe-Nash	4				12				4				0				0			
Foothills	1				1				0				0				0			
Guilford	16				2				3				7				0			
Johnston	1				0				1				0				0			
Lee-Harnett	1				0				0				0				0			
Mecklenburg	44				0				1				9				0			
Neuse	1				0				0				1				0			
New River	4				4				2				4				0			
Onslow	0				0				0				0				0			
OPC	5				4				0				1				0			
Pathways	17				7				2				3				6			
Piedmont	23				4				1				2				0			
Pitt	4				2				0				1				0			
Riverstone	0				2				0				1				0			
Roanoke-Chowan	1				1				0				0				0			
Rockingham	0				0				0				0				0			
Sandhills	1				0				0				1				0			
Smoky Mountain	2				0				0				3				0			
Southeastern Center	11				1				0				4				0			
Southeastern Regional	7				0				1				6				0			
Tideland	1				0				0				0				0			
VGFW	1				1				0				2				0			
Wake	19				5				5				3				0			
Western Highlands	27				5				7				2				0			
Wilson-Greene	2				3				0				0				0			
All LMEs Reporting	262	0	0	0	56	0	0	0	28	0	0	0	67	0	0	0	6	0	0	0

Table 13 - Rate of Other Reported Critical Incidents per 1,000 Active Consumers

This table summarizes other reported critical incidents per 1,000 active consumers. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

Of the "Other Reported Critical Incidents", client absence without notification was the most prevalent with a statewide rate of 1.07 critical incidents per 1,000 consumers. The other types of critical incidents all had statewide rates of 0.27 or less per 1,000 consumers. As with other tables in this report, the wide variation in rates among area programs may be more reflective of reporting differences.

	Other Reported Critical Incidents per 1,000 Active Clients																			
	Client Absence Without Notification for more than 3 Hours				Suspension of a Client from Services				Expulsion of a Client from Services				Arrest of a Client for Violations of Local, State, or Federal Law				Fire or Equipment Failure that has Resulted in Death or Injury			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.51				0.00				0.17				0.00				0.00			
Albemarle	2.58				0.00				0.00				0.00				0.00			
Catawba	1.38				0.00				0.00				0.34				0.00			
Centerpoint	0.41				0.08				0.00				0.08				0.00			
Crossroads	0.61				0.00				0.00				1.22				0.00			
Cumberland	4.52				0.00				0.00				0.82				0.00			
Durham	1.79				0.18				0.00				0.72				0.00			
Eastpointe	1.40				0.00				0.00				0.10				0.00			
Edgecombe-Nash	1.17				3.51				1.17				0.00				0.00			
Foothills	0.18				0.18				0.00				0.00				0.00			
Guilford	1.08				0.13				0.20				0.47				0.00			
Johnston	0.29				0.00				0.29				0.00				0.00			
Lee-Harnett	0.24				0.00				0.00				0.00				0.00			
Mecklenburg	1.07				0.00				0.02				0.22				0.00			
Neuse	0.19				0.00				0.00				0.19				0.00			
New River	0.82				0.82				0.41				0.82				0.00			
Onslow	0.00				0.00				0.00				0.00				0.00			
OPC	0.81				0.64				0.00				0.16				0.00			
Pathways	1.78				0.73				0.21				0.31				0.63			
Piedmont	2.77				0.48				0.12				0.24				0.00			
Pitt	1.00				0.50				0.00				0.25				0.00			
Riverstone	0.00				0.52				0.00				0.26				0.00			
Roanoke-Chowan	0.24				0.24				0.00				0.00				0.00			
Rockingham	0.00				0.00				0.00				0.00				0.00			
Sandhills	0.11				0.00				0.00				0.11				0.00			
Smoky Mountain	0.26				0.00				0.00				0.39				0.00			
Southeastern Center	1.71				0.16				0.00				0.62				0.00			
Southeastern Regional	0.73				0.00				0.10				0.62				0.00			
Tideland	0.18				0.00				0.00				0.00				0.00			
VGFW	0.22				0.22				0.00				0.44				0.00			
Wake	1.86				0.49				0.49				0.29				0.00			
Western Highlands	2.78				0.51				0.72				0.21				0.00			
Wilson-Greene	0.33				0.49				0.00				0.00				0.00			
All LMEs Reporting	1.07	0.00	0.00	0.00	0.23	0.00	0.00	0.00	0.11	0.00	0.00	0.00	0.27	0.00	0.00	0.00	0.02	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00				0.00			
Median	0.73				0.08				0.00				0.21				0.00			
Maximum	4.52				3.51				1.17				1.22				0.63			

Table 14 - Numbers of Consumers in Restraint or Seclusion at Time of Critical Incidents

This table summarizes the numbers of consumers who were in restraint or seclusion at the time of a critical incident. Of the reported cases, nearly all were situations where physical restraint was being used. The total number of cases of restraint or seclusion reported this quarter was slightly higher than the fourth quarter of SFY04, but lower than the first three quarters of SFY04.

	Reported Cases of Consumer in Restraint or Seclusion at Time of Critical Incident															
	Total Cases of Restraint or Seclusion (unduplicated)				Physically Restrained				Chemically Restrained				In Seclusion			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0				0				0				0			
Albemarle	7				7				0				0			
Catawba	28				28				0				0			
Centerpoint	0				0				0				0			
Crossroads	1				1				0				0			
Cumberland	0				0				0				0			
Durham	3				3				0				0			
Eastpointe	7				7				0				0			
Edgecombe-Nash	2				2				0				0			
Foothills	0				0				0				0			
Guilford	20				20				0				0			
Johnston	4				4				0				0			
Lee-Harnett	0				0				0				0			
Mecklenburg	19				19				0				0			
Neuse	0				0				0				0			
New River	6				6				0				0			
Onslow	15				15				0				0			
OPC	1				1				0				0			
Pathways	19				19				0				0			
Piedmont	44				43				0				1			
Pitt	0				0				0				0			
Riverstone	0				0				0				0			
Roanoke-Chowan	0				0				0				0			
Rockingham	1				1				0				0			
Sandhills	0				0				0				0			
Smoky Mountain	1				0				0				1			
Southeastern Center	0				0				0				0			
Southeastern Regional	5				4				0				1			
Tideland	2				2				0				0			
VGFW	4				4				0				0			
Wake	0				0				0				0			
Western Highlands	1				1				0				0			
Wilson-Greene	1				1				0				0			
All LMEs Reporting	191	0	0	0	188	0	0	0	0	0	0	0	3	0	0	0

Table 15 - Rate of Reported Cases of Consumers in Restraint or Seclusion at Time of Critical Incident per 1,000 Active

This table summarizes the rates of reported use of restraint or seclusion at the time of critical incidents per 1,000 active consumers. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

Statewide the rate of reported use of seclusion or restraint at the time of a critical incident was 0.78 per 1,000 active consumers in the first quarter. This is higher than the previous quarter but lower than the SFY04 average quarterly rate of 1.0 per 1,000 active consumers. The wide variation in rates among area programs is likely due to reporting differences.

Rate of Reported Cases of Consumers in Restraint or Seclusion at Time of Critical Incident per 1,000 Active Consumers																
	Total Cases of Restraint or Seclusion (unduplicated)				Physically Restrained				Chemically Restrained				In Seclusion			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.00				0.00				0.00				0.00			
Albemarle	2.26				2.26				0.00				0.00			
Catawba	9.64				9.64				0.00				0.00			
Centerpoint	0.00				0.00				0.00				0.00			
Crossroads	0.20				0.20				0.00				0.00			
Cumberland	0.00				0.00				0.00				0.00			
Durham	0.54				0.54				0.00				0.00			
Eastpointe	0.70				0.70				0.00				0.00			
Edgecombe-Nash	0.59				0.59				0.00				0.00			
Foothills	0.00				0.00				0.00				0.00			
Guilford	1.35				1.35				0.00				0.00			
Johnston	1.18				1.18				0.00				0.00			
Lee-Harnett	0.00				0.00				0.00				0.00			
Mecklenburg	0.46				0.46				0.00				0.00			
Neuse	0.00				0.00				0.00				0.00			
New River	1.22				1.22				0.00				0.00			
Onslow	2.87				2.87				0.00				0.00			
OPC	0.16				0.16				0.00				0.00			
Pathways	1.99				1.99				0.00				0.00			
Piedmont	5.31				5.19				0.00				0.12			
Pitt	0.00				0.00				0.00				0.00			
Riverstone	0.00				0.00				0.00				0.00			
Roanoke-Chowan	0.00				0.00				0.00				0.00			
Rockingham	0.43				0.43				0.00				0.00			
Sandhills	0.00				0.00				0.00				0.00			
Smoky Mountain	0.13				0.00				0.00				0.13			
Southeastern Center	0.00				0.00				0.00				0.00			
Southeastern Regional	0.52				0.42				0.00				0.10			
Tideland	0.36				0.36				0.00				0.00			
VGFW	0.89				0.89				0.00				0.00			
Wake	0.00				0.00				0.00				0.00			
Western Highlands	0.10				0.10				0.00				0.00			
Wilson-Greene	0.16				0.16				0.00				0.00			
All LMEs Reporting	0.78	0.00	0.00	0.00	0.77	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00			
Median	0.20				0.20				0.00				0.00			
Maximum	9.64				9.64				0.00				0.13			

Table 16 - Numbers of Total Reported Uses and Consumers in Seclusion and Restraint

This table summarizes all the reported uses of restraint or seclusion including cases where no critical incident happened. Because of the wording of this reporting requirement, not all providers may be reporting this information to local area authorities. It may be limited to contract providers.

This reporting of all uses of seclusion and restraint and the number of consumers involved are lower this quarter than during the previous quarter. Physical restraint again represents the vast majority (94%) of the reported cases.

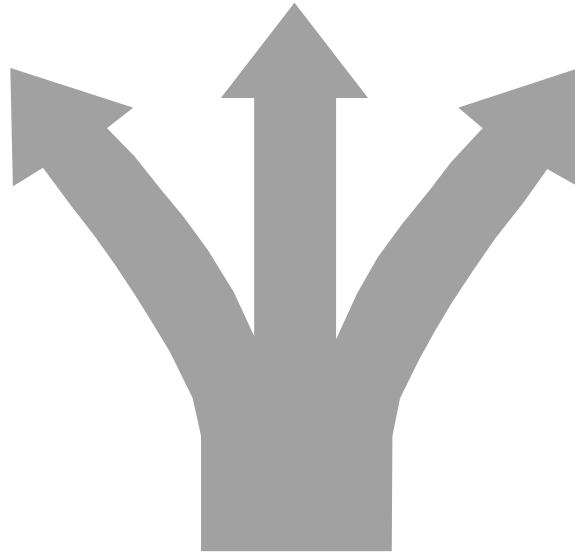
	Reported Uses												Number of Consumers Restrained or Secluded											
	Physical Restraint				Chemical Restraint				Seclusion				Physical Restraint				Chemical Restraint				Seclusion			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	4				0				0				2				0				0			
Albemarle	18				0				0				12				0				0			
Catawba	28				0				0				4				0				0			
Centerpoint	23				0				3				9				0				3			
Crossroads	48				0				25				24				0				14			
Cumberland	18				0				0				14				0				0			
Durham	3				0				0				3				0				0			
Eastpointe	69				0				0				34				0				0			
Edgecombe-Nash	4				0				0				4				0				0			
Foothills	16				0				0				6				0				0			
Guilford	20				0				0				8				0				0			
Johnston	0				0				0				0				0				0			
Lee-Harnett	6				0				0				6				0				0			
Mecklenburg	269				0				19				113				0				13			
Neuse	0				0				0				0				0				0			
New River	40				0				0				23				0				0			
Onslow	15				0				0				11				0				0			
OPC	1				0				0				1				0				0			
Pathways	19				0				0				19				0				0			
Piedmont	43				0				1				23				0				1			
Pitt	0				0				0				0				0				0			
Riverstone	0				0				0				0				0				0			
Roanoke-Chowan	0				0				0				0				0				0			
Rockingham	1				0				0				1				0				0			
Sandhills	38				0				0				22				0				0			
Smoky Mountain	19				0				0				11				0				0			
Southeastern Center	31				0				2				16				0				1			
Southeastern Regional	4				0				1				3				0				1			
Tideland	2				0				0				2				0				0			
VGFW	4				0				0				4				0				0			
Wake	33				0				0				12				0				0			
Western Highlands	50				0				3				12				0				2			
Wilson-Greene	1				0				0				1				0				0			
All LMEs Reporting	827	0	0	0	0	0	0	0	54	0	0	0	400	0	0	0	0	0	0	0	35	0	0	0

Table 17 - Rate of Reported Total Use of Seclusion and Restraint

This table summarizes rates of all reported uses of restraint or seclusion per 1,000 active consumers. This includes cases where no critical incident occurred. These rates offer a better comparison measure than the actual numbers due to the significant variation in program size.

Physical restraint represents the vast majority (94%) of the reported uses of restraint and seclusion. Statewide, the reported use of physical restraint was 3.38 per 1,000 active consumers this quarter. This is lower than the previous quarter. For consumers who were physically restrained, physical restraint was used an average of 2.07 times per consumer during the quarter. This is down from last fiscal year's quarterly average of 2.40 times per consumer.

	Use of Restraint or Seclusion per 1,000 Active Consumer												Average Uses of Restraint or Seclusion per Consumer											
	Physical Restraint				Chemical Restraint				Seclusion				Physical Restraint				Chemical Restraint				Seclusion			
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Alamance-Caswell	0.68				0.00				0.00				2.0				0.0				0.0			
Albemarle	5.82				0.00				0.00				1.5				0.0				0.0			
Catawba	9.64				0.00				0.00				7.0				0.0				0.0			
Centerpoint	1.88				0.00				0.24				2.6				0.0				1.0			
Crossroads	9.74				0.00				5.07				2.0				0.0				1.8			
Cumberland	3.70				0.00				0.00				1.3				0.0				0.0			
Durham	0.54				0.00				0.00				1.0				0.0				0.0			
Eastpointe	6.88				0.00				0.00				2.0				0.0				0.0			
Edgecombe-Nash	1.17				0.00				0.00				1.0				0.0				0.0			
Foothills	2.90				0.00				0.00				2.7				0.0				0.0			
Guilford	1.35				0.00				0.00				2.5				0.0				0.0			
Johnston	0.00				0.00				0.00				0.0				0.0				0.0			
Lee-Harnett	1.43				0.00				0.00				1.0				0.0				0.0			
Mecklenburg	6.56				0.00				0.46				2.4				0.0				1.5			
Neuse	0.00				0.00				0.00				0.0				0.0				0.0			
New River	8.16				0.00				0.00				1.7				0.0				0.0			
Onslow	2.87				0.00				0.00				1.4				0.0				0.0			
OPC	0.16				0.00				0.00				1.0				0.0				0.0			
Pathways	1.99				0.00				0.00				1.0				0.0				0.0			
Piedmont	5.19				0.00				0.12				1.9				0.0				1.0			
Pitt	0.00				0.00				0.00				0.0				0.0				0.0			
Riverstone	0.00				0.00				0.00				0.0				0.0				0.0			
Roanoke-Chowan	0.00				0.00				0.00				0.0				0.0				0.0			
Rockingham	0.43				0.00				0.00				1.0				0.0				0.0			
Sandhills	4.16				0.00				0.00				1.7				0.0				0.0			
Smoky Mountain	2.49				0.00				0.00				1.7				0.0				0.0			
Southeastern Center	4.82				0.00				0.31				1.9				0.0				2.0			
Southeastern Regional	0.42				0.00				0.10				1.3				0.0				1.0			
Tideland	0.36				0.00				0.00				1.0				0.0				0.0			
VGFW	0.89				0.00				0.00				1.0				0.0				0.0			
Wake	3.23				0.00				0.00				2.8				0.0				0.0			
Western Highlands	5.14				0.00				0.31				4.2				0.0				1.5			
Wilson-Greene	0.16				0.00				0.00				1.0				0.0				0.0			
All LMEs Reporting	3.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.22	0.00	0.00	0.00	2.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.54	0.00	0.00	0.00
Minimum	0.00				0.00				0.00				0.00				0.00				0.00			
Median	1.88				0.00				0.00				1.36				0.00				0.00			
Maximum	9.74				0.00				5.07				7.00				0.00				2.00			



**Please give us feedback so we can improve these reports by making them
more informative and more useful to you!**

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